OrthoConnecticut
World-class care, close to home.

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FORM

Revocation
Date Revoked: _____
Initials of Privacy Official:

Patient name (first, last) Date of Birth

Patient's residential address City State Zip Code

Home Phone # Cellular Phone # Email Address

I would like to disclose the following records:

☐ Entire Written Record
(Does not include x-ray images or billing records)

OR

☐ Date span from _____ to _____
including the following types of records:

☐ Diagnostic Reports
☐ Medication & Treatment Records
☐ X-ray images on disc (pre-payment required)
☐ Physician's Office Notes
☐ Billing Records
☐ Other (Please describe below)

I would like these records provided to:

☐ Myself (via mail or e-mail – to patient only)
☐ Provider's Office (via mail only)
☐ Attorney's Office (via mail only)
☐ Other:_____

Send these records via:

☐ USPS Mail to:_____

☐ E-mail to:_____

To disclose records to additional recipients list addresses here:

If sending this form to the office, and seen in Danbury, Southbury or Ridgefield office please send to:
2 Riverview Drive. Danbury. CT. 06810 PH: 203.797.1500 x6666 FX: 203.797.1817 Email: JPacific@myorthoct.com

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Authorization Statements/Signatures:

I understand that once the above information is disclosed it may be re-disclosed by the recipient. At which point the HIPAA Privacy Rule may no longer protect the information.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, it must be done in writing and delivered in person by me to a licensed OrthoConnecticut staff member. I understand that revocation will not apply to information that has already been released in response to this authorization.

I understand that the Facility will not condition the provision of treatment or payment on the provision of this authorization.

I understand Medical Records can only be mailed to an outside office (i.e., Provider, Attorney) and can only be mailed or e-mailed to myself.

I understand there may be a charge of up to .65 per page plus postage for my records.

_____ _____

Signature of Patient of Personal Representative Date

_____

Print Name

_____

Personal Representative's Title or Relation to Patient

This Authorization for Release form is valid for up to 1 year from the signature date unless an earlier date is specified here:

_____

Date

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